Medicare Fee-for-Service Recovery Audit Program

Additional Documentation Limits for Medicare Institutional Providers (i.e. Facilities)

Baseline Additional Documentation Request (ADR) Limits

In November 2015, the Centers for Medicare & Medicaid Services (CMS) modified the additional documentation request (ADR) limits for the Medicare Fee-for-Service Recovery Audit Program for institutional providers, which became effective January 1, 2016. ADR limits for Physician/Non-Physician Practitioners and Suppliers remain unchanged and are not affected by this instruction.

A baseline annual ADR limit is established for each provider based on the number of Medicare claims paid in a previous 12-month period that are associated with the provider's 6-digit **CMS Certification Number (CCN)** and the provider's **National Provider Identifier (NPI)** number. Using the baseline annual ADR limit, an ADR cycle limit is also established. After three (3) 45-day ADR cycles, CMS will calculate (or recalculate) a provider's Denial Rate, which will then be used to identify a provider's corresponding "Adjusted" ADR Limit. Recovery Auditors may choose to either conduct reviews of a provider based on their Adjusted ADR Limit (with a shorter look-back period) or their baseline annual ADR limit (with a longer look-back period).

1. The baseline annual ADR Limit is **one-half of one percent** (0.5%) of the provider's total number of paid Medicare claims from a previous 12-month period.

2. ADR letters are sent on a 45-day cycle. The baseline annual ADR Limit is divided by eight (8) to establish the ADR cycle limit, which is the maximum number of claims that can be included in a single 45-day period. Although the Recovery Auditors may go more than 45 days between record requests, in no case shall they make requests more frequently than every 45 days.

   For example:
   - **Provider A** billed and was paid for 22,530 Medicare claims in 2014. The provider's baseline annual ADR limit would be 22,530 x 0.005, which is 112.65. The ADR cycle limit would be 112.65/ 8, which is 14.08, and would be rounded to **14** additional documentation requests per 45 days.

   - **Provider B** billed and was paid for 255,000 Medicare claims in 2014. The provider's baseline annual ADR limit would be 255,000 x 0.005, which is 1,276. The ADR cycle limit would be 1,276/ 8, which is 159.375, and would be rounded to **159** additional documentation requests per 45 days.

3. ADR limits must be diversified across all claim types of a facility, based on the Types of Bill (TOB) that the provider was paid for in the previous year.

Risk-Based, Adjusted ADR Limits (Updated 5/03/2016)

4. After three (3) 45-day ADR cycles, CMS will calculate (or recalculate) a provider's Denial Rate, which reflects their compliance with Medicare rules. The **Denial Rate** will be calculated using the number of claims containing improper payments (less any determinations that are fully overturned during appeal) divided by the total number of reviewed claims, expressed as a percentage, on a cumulative basis. The Denial Rate will then be used to identify a provider's corresponding "Adjusted" ADR Limit, based on **Table 1**, below. The **Adjusted ADR Limit** will be used for the next three (3) 45-day ADR cycles.

Table 1:

Denial Rate (Range)	Adjusted ADR Limit (% of Total Paid Claims)
91 – 100%	5.0%
71 – 90%	4.0%
51 – 70%	3.0%
36 – 50%	1.5%
21 – 35%	1.0%
10 – 20%	0.5%
4 – 9%	0.25%
0 – 3%	No reviews for 3 (45-day) review cycles

For example:

- After three (3) 45-day review cycles, **Provider A** had 21 claims containing improper payments, out of a total of 42 reviewed claims. The Denial Rate would be 21 ÷ 42, which is 50%. Using Table 1 above, the Adjusted ADR limit would be 1.5% (three (3) times the baseline of 0.5%). In other words, Provider A previously had an ADR cycle limit of 14, and the Adjusted ADR Limit would be 3 x 14, which is 42. This Adjusted ADR limit would then apply to the next three (3) review cycles, after which their Denial Rate would be recalculated.

- After three (3) 45-day review cycles, **Provider B** had 144 claims containing improper payments, out of a total of 477 reviewed claims. The Denial Rate would be 144 ÷ 477, which is 30.18% (rounded to 30%[1]). During this timeframe, Provider B also received Fully Favorable appeal decisions on 48 previously-reviewed claims. Therefore, the Denial Rate would actually be (144 – 48) ÷ 477, which is 20%. Using Table 1 above, the Adjusted ADR limit would be 0.5%, which is the same as the baseline annual ADR limit. This Adjusted ADR limit would then apply to the next three (3) review cycles, after which the Denial Rate would be recalculated.

- After three (3) 45-day review cycles, **Provider C** had 0 (zero) claims containing improper payments, out of a total of 24 reviewed claims. The Denial Rate would be 0 ÷ 24, which is 0%. Using Table 1 above, the Adjusted ADR limit would be "No reviews for three (3) 45-day review cycles", which would be a total of 135 days. After this time frame, reviews would begin again, using the baseline (0.5%) ADR limit.

[1] Rounding is done as follows: numbers ending in less than .5 (i.e. 20.49) will be rounded down to the nearest whole number (20, in this case); numbers ending in .5 or higher (i.e. 20.51) will be round up to the nearest whole number (21, in this case).

Look-back Period

5. Recovery Auditors who choose to review a provider using their Adjusted ADR limit must review under a 6-month look-back period, based on the claim paid date.

   Recovery Auditors who choose to review a provider using their 0.5% baseline annual ADR limit must review under a 3-year look-back period[2].

Use of Extrapolation

6. CMS will consider allowing Recovery Auditors to use extrapolation to estimate overpayment amounts for:
   - Providers who maintain a high denial rate for an extended time period
   - Providers who have excessively high denial rates for a shorter time period
   - Providers with a moderate denial rate, whose improper payments equal a significantly high overpayment dollar amount

7. CMS reserves the right to establish a different record limit when directing the Recovery Auditors to conduct reviews of specific topics or providers.

Questions concerning this update can be directed to RAC@cms.hhs.gov.

[2] Recovery Auditors will still be limited to a 6-month look-back period, from the Date of Service for patient status reviews, in cases where the hospital submits the claim within 3 months of the Date of Service.